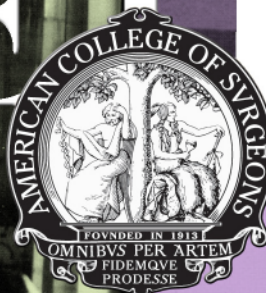
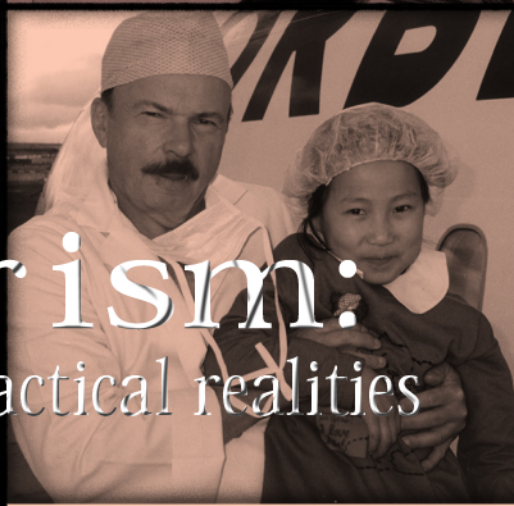
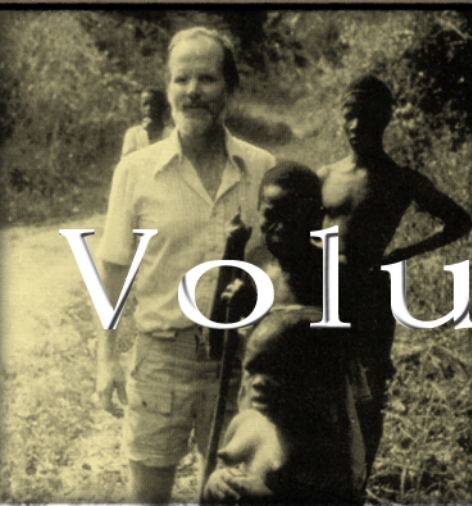


# BULLETIN

AMERICAN COLLEGE OF SURGEONS



October 2002  
Volume 87, Number 10



Volunteerism:  
A look at the practical realities



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## About the cover...

Recent studies of ACS Fellows by the Governors' Committee on Socioeconomic Issues show that many surgeons, such as the individuals on this month's cover, offer their skills and services on a volunteer basis. However, some surgeons have hesitated to provide charitable care because they are concerned about the possibility of liability lawsuits.

On page 8, Howard B. Shapiro, PhD, and Andrew L. Warshaw, MD, FACS, dispel surgeons' fears about liability for surgeons who provide charitable care. More specifically, they provide information about the state and federal laws that protect volunteer surgeons from malpractice lawsuits.



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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.



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# From my perspective

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**A**s I go about the business of the College, I regularly ask myself, “How can the American College of Surgeons become an even more effective representative of the practicing surgeon who is attempting to provide the best possible patient care?” At this point, I have determined that in order to achieve this goal, we need to concentrate on enhancing our achievements in two distinct areas—education and advocacy.

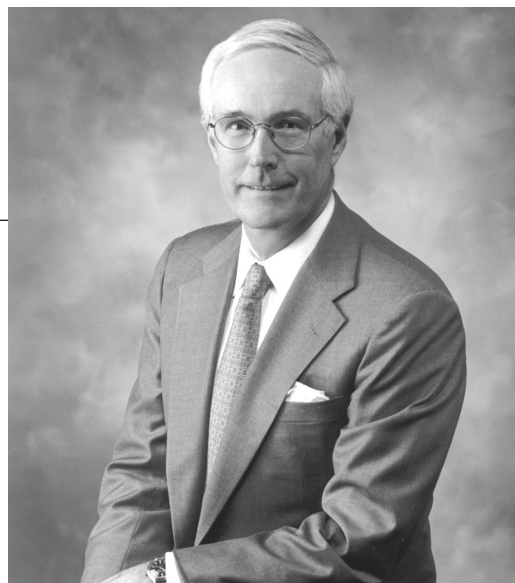
In terms of education, we plan to offer a broader range of enhanced continuing medical education programs, state-of-the-art skills-based courses, seminars aimed at building the level of surgical competence among all Fellows, and practice management workshops. We anticipate that these programs will provide surgeons with opportunities to attain the expertise they need to deliver the most up-to-date and best possible care.

With regard to advocacy, I believe it is imperative that the College help surgeons influence the system we find ourselves working in today. It is this aspect of the College’s activities that I intend to address in this column.

## *Importance of advocacy*

Our health care system continues to become more complex. Many of the difficulties posed by the current system stem from efforts that were designed to control the escalating health care costs that the nation experienced throughout the late 1980s. For example, managed care proliferated because of the belief that it would help to restrain medical expenses. Initially, managed care did slow rising costs. However, it has now proven less effective in this area, and health care costs have escalated 13 to 15 percent annually for the last few years.

Managed care is just one factor that has complicated our modern health care system. Several federal laws enacted in the last 15 years, such as the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act (HIPAA), have created a regulatory maze. Additionally, surgeons are facing decreasing payment, a professional liability insurance crisis, workforce issues, the nursing shortage, and the need for systemic health care reform.



**“I believe it is imperative that the College help surgeons influence the system we find ourselves working in today.”**

To deal with these multitudinous concerns, the College needs to take a very proactive stance in Washington, DC, and at the state level. Our Division of Advocacy and Health Policy has been working hard to tackle these issues, and the College expends a significant amount of time and money each year on this area. Most recently, we have begun the process of adding staff to the division, so that all of our employees can focus more concentrated attention on their assigned issues.

## *Ways to improve*

Additionally, Fellows of the College, Cynthia Brown, Director of the Division of Advocacy and Health Policy, and I have developed a list of possible steps we may take to enhance and improve our advocacy efforts. A summary of these recommendations follows.

- Reorganize the Washington, DC, office to focus on four areas: regulatory affairs and reimbursement, legislative affairs, state issues, and li-



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aision activities with private sector groups and other health care organizations.

- Further the activities of the Health Policy Steering Committee, chaired by Josef E. Fischer, MD, FACS. The committee will meet on a regular basis and establish a more robust agenda to advance the positions of our Fellows. The agenda should be proactive, flexible, and patterned to meet the needs of surgical patients. Members of the committee should accept responsibility for working on specific issues of great concern to surgeons.

- Investigate methods of enhancing communications with our Fellows about advocacy issues at both the state and the federal levels.

- Continue to reach out to other surgical and medical organizations and work jointly with them as appropriate. Alliances with other groups allow us to approach policymakers with a more unified yet diverse range of voices. There is, indeed, “strength in numbers,” and, as a result, coalitions provide greater chances of success. Our outreach activities are supported by the regular specialty society meetings that the College hosts. These meetings have been conducted in an effort to bring surgical societies together around broad issues.

- Employ the new capabilities afforded through the establishment of the American College of Surgeons Professional Association (ACSPA). We have begun the process of establishing a political action committee (PAC) through the ACSPA, which we believe will be particularly useful in our efforts to work with legislators to advance causes for all of surgery.

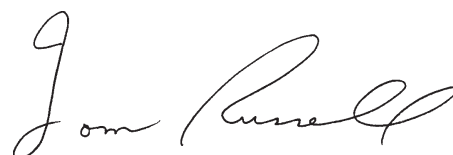
- Groom surgeons to act as leading representatives of the profession in the health policy arena. We are considering the creation of more scholarships and other grant support for individuals who are interested in working with the government. The College also may offer programs aimed at young surgeons to stimulate their interest in socioeconomic issues.

- Continue to develop a network and establish a database of Fellows who have connections with other organizations or politicians who may help to advance the College’s agenda.

- Encourage surgeons to develop relationships with their elected officials and encourage them to express their views and expedite communications on important issues by using the ACS Leg-

islative Action Center (<http://capwiz.com/facs/home/>).

The surgical profession has been under considerable stress for more than a decade. It is clear that we must work very hard to change the system if we are to continue to provide the care our patients need. We not only must carry out our work with great professionalism, but must work to develop a delivery system that is conducive to provision of optimal patient care. As this column demonstrates, the College is making a considerable effort to develop concrete methods of bringing about effective systemic change.



*Thomas R. Russell, MD, FACS*

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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at [fmp@facs.org](mailto:fmp@facs.org).



# FYI: *STAT*

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The American College of Surgeons is offering **two-year faculty research fellowships** to surgeons entering academic careers in surgery or a surgical specialty. Designed to assist a surgeon in the establishment of a new and independent research program, the fellowship awards are in the amount of \$40,000 per year for each of two years to support the research. Applicants should have demonstrated their potential to work as independent investigators. One of the fellowships is named to honor Franklin H. Martin, MD, FACS, the founder of the American College of Surgeons. Another is the C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care. The deadline for submitting applications is November 1, 2002. Application forms may be obtained by contacting [kearly@facs.org](mailto:kearly@facs.org) or by calling 312/202-5281. The requirements and application forms are also posted at <http://www.facs.org/dept/fellowship/acsfaculty.html>.

A new Quarterly Prevention Summary has been added to the series that was launched last winter by the Committee on Trauma's Subcommittee on Injury Prevention and Control. "**All-Terrain Vehicle Injuries and Their Prevention**" outlines the epidemiology, mechanism of injury, and landscape features that influence ATV accidents and injury and prevention efforts, and includes a bibliography. The summary can be viewed at <http://www.facs.org/dept/trauma/atv.html>.

Fellows and Associate Fellows can participate in the ***Journal of the American College of Surgeons Online CME-1 Program*** and earn up to two CME Category 1 credits each month. Visit <http://jacscme.facs.org/> to read each month's designated articles and participate in an exercise in which you evaluate relevant clinical material from the article and apply it to clinical practice. This program is a membership benefit, so you will need to use your Fellowship identification number to access it.

Because the American College of Surgeons recognizes that there may be a benefit for an affiliated organization to invest its funds with those of the College, it has established a **Joint Investment Program for Affiliated 501(c)(3) Organizations**. The College's endowment fund is large enough to take advantage of separately managed accounts, reduced investment fees, and diversification into alternative markets. These advantages are not available to most affiliated organizations because of the smaller size of their investment portfolios. The program is not available to individual Fellows or to organizations with other 501 designations. For more information about the program, contact Gay Vincent at [gvincent@facs.org](mailto:gvincent@facs.org) or call 312/202-5449.

# Dateline|Washington

*prepared by the Division of Advocacy and Health Policy*

## **House makes progress on liability reform**

The College continues to strongly support H.R. 4600, the HEALTH (Help Efficient, Accessible, Low Cost, Timely Health Care) Act of 2002. This legislation mirrors medical liability reforms enacted in California in 1975, including a \$250,000 cap on noneconomic damages. Also among the provisions, the bill would impose a three-year statute of limitations, require proportional damages among defendants, modify the collateral source rule, allow for periodic payments of future damages, and impose limits on attorneys' fees.

At press time, the House Judiciary Committee had approved H.R. 4600 with only minor changes. The legislation was expected to move to the House Energy and Commerce Committee, which shares jurisdiction over the issue, and then to the House floor before Congress adjourns in October.

## **College continues push for Medicare fix**

With additional cuts in Medicare reimbursement looming, the College continues to urge both Congress and the Administration to make appropriate changes to the Medicare reimbursement formula. Over the summer, the College and the rest of the physician community successfully persuaded the House to pass legislation that would provide a payment update of 2 percent in 2003. Currently, the Centers for Medicare & Medicaid Services (CMS) are predicting a 4.4 percent decrease in the conversion factor. The House package also would include positive updates in 2004 and 2005.

The College is working with other specialty societies to encourage the Senate to draft a more generous package. The best-case scenario that is likely to be achieved before the 107th Congress adjourns is a temporary fix in the payment formula, because of the extraordinary cost estimates associated with enacting a permanent solution. Experts predict that Congress will not be able to complete action on many key issues, including Medicare reforms, before the November elections. Consequently, a lame-duck session in December is predicted.

## **College comments on proposed fee schedule**

On August 27, the College submitted comments to CMS on changes the agency proposes to make in physician fee schedule payment policies for 2003. The College applauded a proposal to revise the productivity adjustment to the Medicare Economic Index (MEI), but was critical of CMS's failure to make several changes in the methods and numbers used to calculate the sustainable growth rate and the Medicare payment updates. The College also suggested that CMS seek new money from Congress to apply to the malpractice portion of the fee schedule in order to more accurately reflect the escalating costs of liability insurance. Finally, the College supported the agency's plan to remove noninvasive vascular diagnostic study codes from the so-called zero physician work pool, which would produce higher payments for these services.

Final CMS decisions about Medicare physician payment policies for 2003 are scheduled to be issued by the agency no later than No-



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## **Fellows respond to AHRQ request for comments**

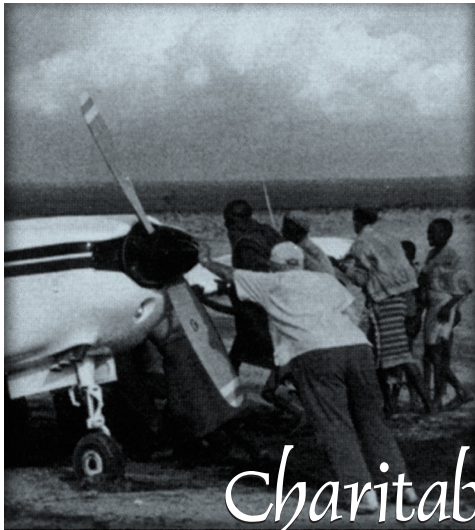
vember 1. The full text of the College's comments on the proposed rule may be viewed online at <http://www.facs.org/dept/hpa/views/medicare2003.html>.

On August 26, the Agency for Healthcare Research and Quality (AHRQ) requested public comment on preliminary quality measures to be listed in its "National Healthcare Quality Report" to Congress. A number of Fellows reviewed and offered observations on the proposed measures. These comments focused on the weaknesses of the clinical sets (cancer and patient safety/complications of care) and the emphasis on using billing data to populate those measures. The College also expressed concern about the dearth of risk-adjustment information and the apparent lack of awareness within the agency regarding the National Cancer Data Base—an excellent tool to monitor cancer outcomes. Finally, a group of Fellows has been activated to provide input regarding the process, clinical reliability of the measures, and the accuracy of the data sets that AHRQ plans to use for the measures.

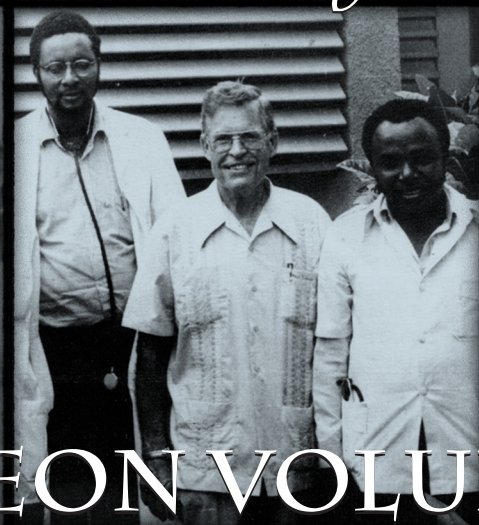
## **Trauma-EMS stakeholders meet in Washington**

On September 9-10, the National Trauma Systems/Emergency Medical Services (EMS) Program held a National Stakeholder's Committee meeting in Washington, DC. The meeting included members of the trauma and EMS community and several key staff from the Health Resources Services Administration, Centers for Disease Control and Prevention, and National Highway Traffic Safety Administration. The committee received an update from Cheryl Anderson, the National Trauma Systems/EMS Program Director, detailing the current status of the fiscal year 2002 state planning grants. Forty-six states and four territories received individual grants of roughly \$40,000 to assist in the development of a comprehensive trauma system or augmentation of current systems already in place. The group also discussed ongoing efforts to revise the *Model Trauma Care Plan*, first drafted in 1992.

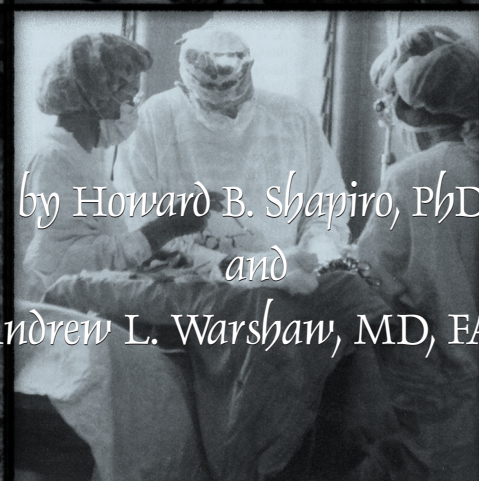
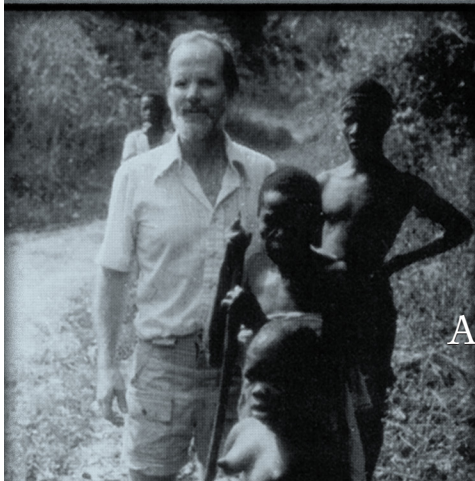




*Charitable immunity statutes shield*



# SURGEON VOLUNTEERS



*by Howard B. Shapiro, PhD,  
and  
Andrew L. Warshaw, MD, FACS*



The Giving Back Program of the American College of Surgeons seeks to stimulate awareness about and opportunities for surgeons to voluntarily contribute their services both domestically and abroad. Supported by the ACS Board of Governors' (B/G) Committee on Socioeconomic Issues and the Institute for Health Policy of the Massachusetts General Hospital in Boston, MA, the effort both catalogues existing charitable programs and facilitates the development of new organizations to deliver surgical care to underserved populations.

Through this project, we have made a number of interesting discoveries about surgeons and the factors that drive them to or discourage them from volunteering their time and skills. One deterrent to volunteerism appears to be the possibility of being sued.

This article summarizes why surgeons so often do contribute their skills without the expectation of financial gain. It also reviews some of the ways the Committee on Socioeconomic Issues plans to stimulate interest in volunteerism and shows that concerns about liability lawsuits should be minimal due to the existence of state and federal statutes designed to protect volunteers.

### Why surgeons volunteer

As part of the Giving Back Program, we have convened focus groups of the Fellows during the last two Annual Clinical Congresses. These discus-

sions have unearthed a wealth of charitable projects to which surgeons provide their skills in clinical care or surgical education. Some surgeons pursue these activities on a regular and continuing basis, some provide basic surgical care, and some focus on assisting people with specific problems such as children with pediatric anomalies or battered women who need facial reconstruction. These surgeon volunteers may receive support from church groups, community organizations, surgical specialty societies, or motivated, public-spirited individuals such as retired surgeons who want an opportunity to continue to be useful. A linking theme across the spectrum of participants has been the satisfaction and fulfillment in being able to give a part of themselves back to society.

### Encouraging volunteerism

More than 600 Fellows responded to an invitation in the January 2002 issue of the *Bulletin* to participate in a more comprehensive study of volunteerism by surgeons and to express their interest in becoming involved. The Board of Governors is considering a proposal that the College recognize outstanding examples of "giving back" by surgeons with an award, which would be presented annually at the Clinical Congress, perhaps in conjunction with an illustrative presentation by the recipient individual or group.

The Giving Back Program will eventually include a Web site that will encompass a clearinghouse that can link potential participants with opportunities. The Web site also will identify other relevant medical and surgical organizations and

Opposite page: A few scenes from *Bulletin* articles by ACS Fellows who have done volunteer work.

Left to right, top row: Volunteers from the African Medical Education and Research Foundation, as reported by Thomas D. Rees, MD, FACS, and colleagues (*ACS Bulletin*, (79[10])); a Kyrgyzstan hospital scene, as described by Bernard J. Leininger, MD, FACS (82[9]); and Harold P. Adolph, MD, FACS, in surgery in Galmi, Niger, West Africa (82[6]).

Second row: William R. Greene, MD, FACS, in surgery at Hôpital Lumière in Bonne Fin, Haiti (86[8]); Glenn M. Gordon, MD, FACS (center), with Dr. Swai and Dr. Mariwa in Dar es Salaam, Tanzania (74[3]); and Sylvia Campbell, MD, FACS, with "Baby Wadlin" Bernoit, in Mombin Crochu, Haiti (84[10]).

Third row: H. C. John Chiang, MD, FACS (back row, center) with fellow volunteers preparing to supply post-earthquake aid in Gih-gih, Taiwan (85[1]); Wilma Conger Perrill, MD, and Charles V. Perrill, MSc, MD, FACS, en route to India in 1940 (82[10]); and Donald C. Mullen, MD, MDiv, FACS, and patient in Fangok, Sudan (84[9,10]).

Fourth row: Glenn W. Geelhoed, MD, FACS, during one of his many trips to Africa (83[9]); Robert K. Finley, Jr., MD, FACS, in surgery in Jamaica (81[6,7]); and Walter J. Kahn, MD, FACS, with a patient in front of the ORBIS aircraft (87[2]).

**Dr. Shapiro** is a consultant for *Volunteers in Health Care*, Bethesda, MD.



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suppliers and provide a “tool kit” for building a program. The tool kit—currently being developed based on interviews being conducted with experienced volunteer organizations, such as Volunteers in Health Care (VIH)—will discuss the necessary elements and resources for success. It also will suggest the means for gathering the necessary components and possible roadblocks.

### *Liability as a roadblock*

Liability exposure is usually one of the first concerns raised by physicians who are interested in volunteering to care for the uninsured. However, few liability claims actually arise from these charitable efforts, and surgeons who volunteer in free clinics or as part of other local initiatives have some liability protection under state laws and a federal statute. These laws are summarized in a VIH publication entitled *Charitable Immunity Manual: A Review of U.S. Charitable Immunity Legislation for Volunteer Health Care Providers*. The manual, which includes a state-by-state table summarizing statutory provisions, may ease the concerns of many surgeons who want to volunteer and provides guidance to those seeking passage of similar laws where there are none—notably in New York, Massachusetts, and California.

VIH is a not-for-profit, national resource center providing one-on-one technical assistance, how-to manuals, software programs, and seed funding to promote organized volunteer efforts by physicians and other professionals to care for uninsured and underserved patients. With support from the Robert Wood Johnson Foundation, the manual and other VIH products and services are provided at no charge.

### *Approaches to charitable immunity*

In contrast to “Good Samaritan” laws that protect health care professionals responding to an emergent situation, charitable immunity laws in 42 states and the District of Columbia apply to routine care provided by clinician volunteers. According to the manual’s author, Paul Hattis, MD, JD, MPH, most states choose one of two routes to provide protection. Some states change the negligence standard of care; that is, they raise the standard from simple negligence to gross negligence. Often called a “willful or wanton” or “reckless” standard, this approach makes it more difficult to

prove negligence. It also is the approach used in the federal statute.

Other states extend to volunteer clinicians the same protections they grant to government employees. Under this model, referred to as the “state tort claims act,” the state establishes a legal defense fund to cover monetary damages and legal defense costs. Often these statutes cap the total compensation that may be paid for claims. Certain conditions may be specified, such as the setting in which the care is delivered or the existence of a formal agreement between the clinician provider and the state.

The State of Florida, for example, appears to have found a successful formula through its Volunteer Health Care Provider Program. Under a law enacted in 1992, physicians enter into an agreement with the state to care for uninsured patients and are granted the states’ sovereign immunity protection. Writing in the *Archives of Internal Medicine* (October 18, 2001), a Florida Department of Health official indicates that 18,000 volunteer practitioners provided services valued at \$66 million in fiscal year 1999-2000.

Neither of the two major approaches completely limits a patient’s right to initiate a liability action against a volunteer nor ensures that a lawsuit will be easily dismissed. But changing the negligence standard raises the bar for plaintiffs, and indemnity under a state tort claims act protects against financial loss. Several states combine aspects of both models.

Other approaches are summarized in the VIH  
*continued on page 35*

**Dr. Warshaw** is Chair, ACS Board of Governors’ Committee on Socioeconomic Issues, and surgeon-in-chief and chair, department of surgery, Massachusetts General Hospital, Boston, MA.







## *Fellowship programs place surgeons in policymaking positions*

*by Barbara Cebuhar,  
Communications Specialist,  
Division of Advocacy and Health Policy*

There is an old saying that developing legislation is a lot like making sausage; the results taste great, but you probably wouldn't want to eat it if you had to watch it being made. Nonetheless, many surgeons recognize that the regulatory and health policy climate affecting their profession has changed dramatically in recent years, and that policy decisions made by legislators and regulators have an impact on many aspects of surgical practice. The decline in payment levels and clinical autonomy, as well as the escalating "hassle factor," have been growing and ultimately stand to affect how surgeons provide services to their patients. The ongoing effect of public policy, combined with the realization that surgeons' voices have been largely lacking at many negotiating tables, has driven some surgeons to become more politically active.

Surgeons take varying approaches to ensure that their perspectives and experiences are taken into account and that new policies reflect the "real world" of surgical practice. Some Fellows have elected to exert influence over the process through their involvement in chapter legislative efforts at the state and federal levels, including participation in the College's Capitol Hill visit program. Others have lent their expertise to a variety of federal and state regulatory committees and panels. Still others have chosen a very different route, taking advantage of opportunities to be directly engaged in policymaking, generally

through fellowship programs that allow clinicians to work directly on Capitol Hill or in the White House.

The White House Fellows and the Robert Wood Johnson Fellowship programs are two of the many distinguished programs that allow clinicians to come to Washington, DC, and immerse themselves in the health policy mixing bowl at a high level. While the objectives, stages of career at which individuals may participate, and the venues of the two programs differ slightly, they both share a commitment to offering surgeons an opportunity to put their experiences to work and to put complicated policies into action. Individuals who have opted to participate in these programs and experience firsthand the legislative and executive branch deliberations on health policy all seem to agree: People who aren't at the table articulating their position and how it affects patients and the population at large can't complain about the outcomes.

### ***The White House Fellows program***

Lance Wyatt, MD, is currently chief resident in the combined plastic surgery residency training program at Harvard University and a member of the ACS Candidate Group. Dr. Wyatt was in the fourth year of his general surgery residency at the University of California, Los Angeles (UCLA), when he realized that the forces affecting medicine and patients often existed outside the day-to-day operations of a university hospital. "I had already matched in plastic surgery and came to realize that if physicians were going to have any impact on the future of health care and medicine, it was important to step up to the table and be immersed in the process of governing.

"Personally and professionally, the White House Fellows program seemed like a good fit," he said. "I had a choice between a chief residency position at UCLA or the White House Fellows program, and I chose the Fellows program. It took some convincing. My mentors, my parents, and my colleagues all wondered why I would give up the traditional path of working as a chief resident. Some viewed this move as a distraction from the traditional model of surgical training. But other outside-the-box thinkers, who realized the growing impact of policy on practice,



Dr. Wyatt with White House Fellows and the President. Front row, left to right: Sunil Garg, Daniel Feldman, Melissa Goldstein, Dr. Wyatt, Jacqueline Lain, Esther Benjamin, Maj. Peter Najera, and Ariel Zwang. Back row: Lt. Christopher Moore, Timothy C. Wu, Gary Hall, then-President William J. Clinton, Khalid Azim, Lt. Juan M. Garcia III, Reynaldo A. Valencia, and Maj. Barrye L. Price, PhD.

thought it would be a wonderful opportunity to explore—one that would help make me a better surgeon and proponent for my profession." (See photo, above.)

In general, the current educational process doesn't encourage stepping outside the discipline. "But did you know that there were five physicians who were signers of the Declaration of Independence? Physicians have a rich history and commitment to society, but over time our participation in government has waned," Dr. Wyatt said. "At least for the purposes of enlightened self-interest physicians would be wise to be active participants in a process that holds sway over the practice of medicine."

Dr. Wyatt noted, "Our training, skills, and value set are essential to the debate—especially on issues that affect surgery and our patients. Surgeons are healthy skeptics, are data-driven; they make rapid decisions at all hours based on incomplete data, are decisive, thoughtful, and thorough, and, most of all, have been coached throughout their surgical training at maintaining good patient-physician relationships. I believe those same skills lend themselves to the process of governing," he added.

"The year was over before I knew it, and I



Dr. Miller and other members of the RWJ Fellowship Program. Left to right: Lisa Kaplowitz, MD; Dr. Miller; Burton Edelstein, DDS; Linda Degutis, RN, PhD; Karen Guice, MD, FACS; and Clyde Evans, PhD.

wouldn't trade it for anything. Health care is changing and medicine is at a critical juncture," Dr. Wyatt said. "Applications to medical schools are down, and some general surgery residencies are not filling their categorical spots. It may be time to consider how we are going to grow and groom the next generation of clinical leaders and to understand that there are new venues where our experience is critical."

While the White House Fellows program is usually considered an early career stop for most participants, the ages vary, and there have been several physicians who participated in the program later in their careers. In fact, according to Dr. Wyatt, "Jeff Colyer, MD, a plastic surgeon who was a White House Fellow in 1980s, is currently running for Congress in the Third District in Kansas. That's what we need, surgeons taking the risk and stepping to the table if you really want change."

### ***The Robert Wood Johnson Fellowship***

The Robert Wood Johnson (RWJ) Fellowship is specifically designed for mid-career clinicians who have significant experience under their belts. Fellowships run for three years, with 12 to 16 months of actual hands-on work experi-

ence in the Washington, DC, policy arena. Fellows receive a stipend of \$80,000 per year, benefits, housing, and travel expenses.

Robert Miller, MD, FACS, currently in the office of the dean at the University of Nevada School of Medicine, participated in the RWJ Fellowship in 1997 (see photo, left). He characterized it as "a life-altering and invaluable experience, one of the high points of my personal and professional career."

Dr. Miller worked in Sen. John Breaux's (D-LA) office in 1997 during the heated debates surrounding the Balanced Budget Act of 1997. He handled a number of issues for the senator that were outside his field of otolaryngology. For example, Dr. Miller worked with Senator Breaux and his staff to develop a demonstration program to test whether an insurance model resembling the Federal Employees Health Benefits Program (FEHBP) would work to control costs and provide the same level of services for Medicare beneficiaries. That proposal passed in the Senate, but did not fare well in the House-Senate conference committee. But, as Dr. Miller commented, "You learn that if a bill or an action doesn't make it through the legislature the first time, it could be introduced again during the next session. Senator Breaux's FEHBP Medicare demonstration project resurfaced as part of the special Medicare commission's report and missed passage by only one vote. I fully expect to see the measure come again in the years to come."

Dr. Miller suggests that the lessons learned are particularly important for all surgeons to appreciate. "You learn that each accomplishment, however small, is hard-won. There are tremendous resources throughout government available to you as a citizen, as a practitioner, and for your patients. You also learn that there are dedicated, smart people working in your government—professionals who are committed to doing the right thing amidst very difficult and competing pressures. The benefit of being a surgeon at the table is that your hands-on experience with patients means you can help formulate programs that will work and minimize the problems they might create at the front lines of practice."

Dr. Miller, however, noted that certain aspects of the RWJ Fellowship program may be obstacles





Dr. Rice in front of the White House with other RWJ Fellows. Left to right: Ken Chance, DDS; Steve Ringel, MD; Jay Himmelstein, MD, MPH; Phil Hofschire, MD; Marion Ein Lewin, former director of the RWJ Health Policy Fellowship program; Robert Frank, PhD; Irwin Merkatz, MD; and Dr. Rice.



Dr. Dunn and fellow RWJ Health Policy Fellows. Left to right: Angela Mattie, Mario F. Pacheco, Anne De Biasi, Patience H. White, Dr. Dunn, and Kristofer Hagglund.

to participation. "A lot of surgeons would be concerned about the lost income, the turmoil of moving a family, the potential loss of stature or placement in their institutional structure, and the loss of surgical skills while devoting a 110 percent effort to learning and working in the policy arena," he said.

"However, all that was worth it to me, as I learned how the process works most effectively and now can apply those skills on behalf of my institution, my profession, and my patients," Dr. Miller said. "The surgical skills came back, almost immediately. And, while there was a loss in income and I had to use some of my savings, the experience helped set the stage for the work I'm doing now at the University of Nevada and for the College as part of its Health Policy Steering Committee."

Charles Rice, MD, FACS, vice-chancellor of the University of Illinois at Chicago, was at the University of Washington when he worked from 1991 to 1992 as a RWJ Fellow for Sen. Tom Daschle (D-SD) (see photo, above left). "Sena-

tor Daschle wanted us to develop a workable single-payor proposal. While that proposal did not pass, it helped inform the larger discussions during the health care debate of 1993-1994. I also worked on a toxic exposure registry for veterans of the Gulf War, and programs to address fetal alcohol syndrome on the Indian reservations," he said.

"Perhaps one of the greatest insights I gained in the process was a new understanding of how policymakers work on very complicated issues," Dr. Rice said. "They are surrounded by competing and persistent demands from constituent and vocal interest groups. There are also painful compromises that have to be made, and it is important to understand the conflicting dynamics."

But the most compelling reason for Dr. Rice's decision to take the time off from practice was his belief that "something will ultimately happen that will fix the fundamental flaws in the health system. It is imperative that surgeons be there." The most frustrating aspect of the time

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Dr. Rice spent on the Hill was confronting the fact “that resolution of some of the biggest drivers of decreasing health care costs—using motorcycle helmets or seat belts, restricting handguns, stopping drunk drivers and smoking—remained issues untouched and out of reach. Ultimately, I thought it was best that a surgeon be at the table during these health policy discussions to ensure that our patients and practices were heard and understood.”

Edward J. Dunn, MD, MPH, FACS, was a thoracic surgeon working at the Milwaukee Medical Clinic and Columbia Hospital when he decided to take a different course and pursue a master of public administration degree at the Kennedy School of Government, followed by a master of public health at the Harvard School of Public Health. The following year he became a RWJ Health Policy Fellow and worked as legislative staff for Sen. Edward Kennedy (D-MA). (See photo, p. 14, right.)

“I couldn’t have done this when my children were small. But, because of the increasing complications and involvement of government in health policy, I decided it was essential to understand how Congress works. It truly is a different planet, and there is no way to access Washington, DC, and change health policy without seeing it, experiencing it, and getting involved with the process,” Dr. Dunn said.

“The people on the Hill often advanced what seemed like ‘great’ ideas about health policy, but many of them had never experienced the health care system in their lives, much less known how to care for patients. Working for a senior member of the Senate and on the Health, Education, Labor and Pension Committee meant that we were valuable commodities, counted on for our “real world” sensibilities of what would really work for patients, communities, and practices. Also, there are very few physicians in government, and the scarce number who are there generally bring a primary care medical training perspective. Policymakers need a surgeon’s sense of the science, innovation, application of technology, and ability to allocate resources.”

“There were several lessons I learned,” Dr. Dunn added. “First, people on the Hill—from members to staff—were smart, hard-working, motivated, and had a great work ethic. But, they



Dr. Hoopes

did not have a lot of life experience—much less a practitioner’s experience of what works and what doesn’t. There were a lot of elegant ideas floated that would get an ‘A’ at the Kennedy School, but wouldn’t work in practice. RWJ fellows, and especially surgeons, were essential in bridging the worlds of health and policy.”

The second lesson Dr. Dunn said he learned “was that James Madison’s vision of a deliberative democracy is alive and well. It usually takes several sessions for good ideas to become law. Medicare and Medicaid, for example, germinated for 20 years before laws were passed. Big reforms don’t happen in Washington often.”

Finally, Dr. Dunn noted that the process can sometimes be disheartening. “Politics, in some cases, trumps good policy. Members want to get reelected. The interest groups and political action committee contributors hold their attention. There are painful compromises that oftentimes are made. But, the good we did overshadows the frustration factor. I left with enduring relationships, an insider’s view of how to insert your insights into the policy development process, and a realization that if it doesn’t work at the federal level, there is always an opportunity at the state and local levels.”

John E. Hoopes, MD, FACS, now retired from Johns Hopkins University Medical Center in Baltimore, MD, and enjoying an active life at Lake

*continued on page 35*

# Statement on the use of animals in research, education, and teaching

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*The following statement was originally published in the February 1991 issue of the Bulletin as the "Statement on the Use of Animals in Research." This revised statement incorporates language related to recent changes that have been made to the Federal Animal Welfare Act, Regulations, and Standards.*

The American College of Surgeons supports the responsible use and humane care and treatment of laboratory animals in research, education, teaching, and product safety testing in accordance with applicable local, state, and federal animal welfare laws. Further, the membership believes that only as many animals as necessary should be used; that any pain or distress animals may experience should be minimized or alleviated; and that, wherever feasible, alternatives to the use of live animals should be developed and employed.

The American College of Surgeons believes that now and in the foreseeable future it is not possible to completely replace the use of animals and that the study of whole living organisms, tissues, and cells is an indispensable element of biomedical research, education, and teaching.



# In compliance...

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## ...with HIPAA rules

*by the Division of Advocacy and Health Policy*

**T**he Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all surgical and medical practices develop “notices of privacy practices.” These announcements should be included in the authorizations forms discussed in this column last month. They also must be written in “plain language,” including any privacy provisions mandated through state law as well as the following items.

1. A header stating, “This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.”

2. Information on uses and disclosures, including at least one example of the types of uses and disclosures that the practice is permitted to make for treatment and payment and any situation for which authorization or consent forms are needed. Though consent forms are no longer required under the most recently finalized version of the HIPAA regulations, practices should check state law to determine if such a form is required. The notice must contain a statement notifying patients that other uses and disclosures will be made only with the individual’s written authorization and that the individual may revoke such authorization.

3. Patients must be informed that the practice may contact them to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest.

4. The notice must state that the practice may deny a patient access to that information if, in the physician’s professional judgment:

- The patient’s access may endanger the life or safety of the patient or another person.
- The information makes reference to another person who is not a health care provider and that the access requested is reasonably likely to cause substantial harm to that person.
- The request for access is made by a patient’s representative and the provision of access to that representative is reasonably likely

to cause substantial harm to the patient or another person.

The practice must include information about these denial provisions and the practice’s process for contesting denial of access.

5. A statement of the practice’s duties, including the duty to ensure the privacy of confidential information and to inform the patient of any changes in the notice. The statement must also describe how it will provide individuals with a revised notice.

6. A statement that patients may complain to the practice and to the Secretary of the U.S. Department of Health and Human Services if they believe their privacy rights have been violated. This portion of the notice must include a brief description of how the individual may file a complaint and a statement that the individual will not be retaliated against for filing a complaint.

7. The name, or title, and telephone number of the practice’s privacy officer who patients would contact if they had a complaint.

8. The date the notice is effective and/or revised. Practices are required to document compliance with notice requirements by retaining copies of the versions of the notice issued. Practices need to consider how they will notify patients of revisions to the notice and how they will provide the revised document to patients.

The notice must be prominently displayed in the office. If the practice maintains a Web site, the notice must be prominently posted there. Because in most cases surgeons are considered health care providers with direct treatment relationships, they must also provide a copy of the notice to a patient either in paper form or by e-mail if a patient agrees to electronic notice at the time of first service delivery to the patient. We would suggest adding that statement to the initial intake form. Document that the notice was provided or that a good-faith effort was made to provide the notice to the patient. Simply including an area on an existing form that

*continued on page 33*

# Keeping current

## What's new in *ACS Surgery: Principles and Practice*

by Erin Michael Kelly, New York, NY

Following are highlights of recent additions to the online version of *ACS Surgery: Principles and Practice*, the practicing surgeon's first and only Web-based and continually updated surgical reference. A sample chapter and detailed information on *ACS Surgery*, including how to save \$20 on a subscription to the online version, are available by visiting [www.acssurgery.com/learnmore.htm](http://www.acssurgery.com/learnmore.htm).

### II. Common Presenting Problems

3. *Breast Complaints*. Barbara L. Smith, MD, PhD, FACS, and Wiley W. Souba, MD, ScD, FACS. In their updated chapter, Drs. Smith and Souba

cover workup, diagnosis, and management of breast complaints, including a number of significant advances. In the area of breast cancer chemoprevention, a number of newer agents may possess some effectiveness. Aromatase inhibitors, which have been used as second-line therapies after tamoxifen in cases of advanced breast cancer, may exert chemopreventive effects by inhibiting parent estrogens and their catechol metabolites, thereby preventing cancer initiation. In addition, gonadotropin-releasing hormone agonists, monoterpenes, isoflavones, retinoids, rexinoids, vitamin D derivatives, and inhibitors of tyrosine kinase are all undergoing evaluation in clinical or preclinical studies with a view to assessing their potential chemopreventive activity. Whether any of these compounds will play a clinically useful role in preventing breast cancer remains to be seen. Subscribers may view the full text of "Breast Complaints" at [www.acssurgery.com](http://www.acssurgery.com).

### V. Operative Management

12. *Laparoscopic Cholecystectomy*. Gerald M. Fried, MD, FACS; Liane Feldman, MD; and Dennis R. Klassen, MD. Drs. Fried, Feldman, and Klassen describe their approach and discuss current indications and techniques for imaging and exploring the common bile duct. This summary includes their review of intraoperative laparoscopic ultrasonography for evaluation of the biliary tree, an emerging alternative for evaluation of the biliary tree, which appears to be as accurate as intraoperative fluorocholangiography in identifying biliary stones. According to the authors, this modality has several advantages over conventional cholangiography. It does not expose patients and staff to radiation; contrast agents are unnecessary; there is no need to cannulate the cystic duct; significantly less time is required; the capital cost of most ultrasound units is less than that of fluoroscopic equipment; and disposable cholangiogram catheters are unnecessary. Subscribers may view

### Online discount

As a special member benefit for ACS Fellows, Associates, and Candidates who are not already subscribers to the College-sponsored *ACS Surgery: Principles and Practice*, we are pleased to offer a \$20 discount on subscriptions to the online version of the reference. You pay an annual subscription fee of \$179, instead of the customary \$199 rate. Please go to [www.acssurgery.com/learnmore.htm](http://www.acssurgery.com/learnmore.htm) for more information and to save \$20 on the online version.

Subscribers to the print and CD-ROM versions of *ACS Surgery* continue to receive free online access to the monthly updates and full text by visiting [www.acssurgery.com](http://www.acssurgery.com). You will need your nine-digit account number, which may be obtained by calling 800/545-0554 or 914/962-4559 (outside the U.S.), by faxing 914/962-5076, or by e-mailing [acssurgery@webmd.net](mailto:acssurgery@webmd.net). Updates also are available quarterly through subscription to the *ACS Surgery* CD, which incorporates every online update from the previous three months, and yearly through subscription to the annual hardcover edition of *ACS Surgery*, which incorporates every online update from the preceding year.

the full text of "Laparoscopic Cholecystectomy" at [www.acssurgery.com](http://www.acssurgery.com).

## V. Operative Management

**31. Hepatic Resection.** Yuman Fong, MD, FACS. In his new chapter, Dr. Fong focuses on the technical aspects of hepatic resection, emphasizing efficiency and safety and taking into account recent developments, current controversies, and special operative considerations (such as the cirrhotic patient and repeat liver resection). When possible, he provides options for major techniques. For example, he points out that intrahepatic vascular pedicle ligation can serve as an alternative to extrahepatic dissection and ligation for controlling vascular inflow to the liver. This alternative technique has the advantages of being rapid and of being unlikely to cause injury to the vasculature or the biliary draining of the contralateral liver. Given adequate intrahepatic definition and control of the portal triads supplying the area of the liver to be resected, one can readily isolate the various major pedicles by using simple combinations of hepatotomies at specific sites on the inferior surface of the liver.

Laparoscopic hepatic resection has been greatly facilitated by several recent technologic advances, including laparoscopic staplers and ultrasonic dissectors, which can be used for ligation of the hepatic vasculature and transection of liver parenchyma. The most important advance, however, is the hand-access port, a small port through which one hand can be introduced into the abdomen for a hand-assisted laparoscopic resection. With this approach, the surgeon not only regains a measure of tactile sensation but is able to employ the best liver retractor available—the hand. Moreover, direct manual compression of any bleeding vessels is once again possible, and the incision made for the hand-access port is also used for extraction of the resected specimen.

Subscribers may view the full text of "Hepatic Resection" at [www.acssurgery.com](http://www.acssurgery.com).

## VIII. Postoperative Management


**1. Postoperative Management.** Samir M. Fakhry, MD, FACS; Edmund J. Rutherford, MD, FACS; and George F. Sheldon, MD, FACS. This updated chapter focuses on postoperative management of more seriously ill patients undergoing major operations,

for whom outpatient and fast-track approaches generally are poorly suited. Drs. Fakhry, Rutherford, and Sheldon make specific recommendations on matters that affect patient care. In their discussion of preemptive anesthesia, they point out techniques utilizing epidural anesthesia or major field block achieve a greater reduction in perceived pain than general anesthesia does, and these techniques greatly reduce the need for postoperative analgesics while enhancing postdischarge activity. Epidural anesthesia and other regional techniques are being applied more frequently now that a number of trials have found them to be superior to general anesthesia. In the case of epidural anesthesia, the catheter can be used to provide sustained pain relief for several days after operation. This approach is particularly useful for treating patients who have undergone operations on the lower abdomen or the lower extremities. It can lead to earlier mobilization and return of bowel function after operation, thereby shortening hospital stay.

Subscribers may view the full text of "Postoperative Management" at [www.acssurgery.com](http://www.acssurgery.com).

## Looking ahead

New and revised chapters scheduled to appear as online updates to *ACS Surgery: Principles and Practice* in 2002 include the following:

- "Ultrasonography: Surgical Applications," by Grace S. Rozycki, MD, FACS.
- "Substance Abuse," by Mark Kirk, MD, and John A. Marx, MD.
- "Injuries to the Chest," by Asher Hirshberg, MD, and Kenneth L. Mattox, MD, FACS.
- "Emergency Department Evaluation of the Patient with Multiple Injuries," by Felix Battistella, MD, FACS.
- "Multiple Organ Dysfunction Syndrome," by John C. Marshall, MD, FACS.
- "Organ Procurement," by Charles M. Miller, MD, FACS, and Thomas R. Starzl, MD, FACS.
- "Postoperative Pain," by Henrik Kehlet, MD, PhD. 

**Mr. Kelly** is editor, *What's New in ACS Surgery: Principles and Practice*, *WebMD Reference*, New York, NY.



# Socioeconomic tips of the month

## Responses to common coding questions

by the Division of Advocacy and Health Policy

**T**his column addresses questions from Fellows and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If you would like to see other topics addressed in future columns, please contact the Division of Advocacy and Health Policy by fax at 202/337-4271, or via e-mail at [HealthPolicyAdvocacy@facs.org](mailto:HealthPolicyAdvocacy@facs.org).

### Coding hotline questions

One of the benefits that the ACS provides to Fellows is access to a coding hotline (800/ACS-7911). ACS Fellows are entitled to 10 consultation units (CUs) per 12-month period. Practices that have coding questions may contact the hotline between 8:00 am and 6:00 pm, CST, holidays excluded. Here are the answers to some frequently asked questions.

**Q.** How do we code for a laparoscopic incisional hernia repair with mesh? Is it appropriate to use code 49568 in addition to code 49659?

**A.** You would not use code 49568, Implantation of mesh or other prosthesis for incisional or ventral hernia repair (list separately in addition to code for the incisional or ventral hernia repair). It is only appropriate to report the use of mesh when an open incisional hernia repair is performed. When the procedure is performed laparoscopically, report code 49659, Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy, and include the value of the extra work of the mesh. Of course, the expense of the mesh itself is borne by the facility.

**Q.** We submitted a claim for a procedure using the -22 modifier and the modifier was not allowed. What can we do?

### Around the corner

#### November

- The 90-day implementation period during which Medicare will allow claims to be submitted with the 2002 and 2003 versions of ICD-9-CM diagnosis codes continues until December 31. After that, only the 2003 version will be accepted.
- 2003 Medicare fee schedule scheduled for release. Medicare carriers distribute fee schedules to providers.
- CPT 2003 available.

**A.** The -22 modifier is used to indicate that a procedure was a complex or an unusual operative case. Due to misuse of modifier -22, many payors are denying it. Medicare "carriers continue to have authority to increase payment for unusual circumstances (-22) or decrease payment for reduced services (-52), based on review of medical records and other documentation. Modifier -22 may be reported with all surgical procedures, including assistant-at-surgery services, regardless of the duration of the global period. Documentation of the unusual circumstances must accompany the claim (for example, a copy of the operative report and a separate statement written by the physician explaining the unusual amount of work required)."<sup>\*</sup> Keep in mind that many payors will not pay extra for anything less than 150 percent of the work of the regular procedure.

**Q.** Our doctor performed a procedure, and the charge sheets indicate that he did control of bleeding. How do we code for that procedure?

All specific references to CPT terminology and phraseology are: CPT only © 2002 CPT American Medical Association. All rights reserved.

<sup>\*</sup>American Medical Association: *Medicare RBRVS: The Physicians' Guide*. Chicago, IL: American Medical Association, 2000, p. 83-84.

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**A.** When a major procedure is performed, control of bleeding is included in the procedure. If the major procedure performed was control of bleeding, identify the site and method used and then code accordingly. Some codes that may be appropriate are the 35201 series, Repair blood vessel other than for fistula, with or without patch angioplasty, or the 37565 series, Ligation and other procedures.

**Q.** How do we code for the insertion of a temporary pacemaker?

**A.** Use code 33210, Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure).

**Q.** How do we code for the closure of a colostomy?

**A.** Report code 44620, Closure of enterostomy, large or small intestine.

**Q.** How do we code for the repositioning of a jejunostomy tube through the duodenum?

**A.** Report code 43761, Repositioning of the gastric feeding tube, any method, through the duodenum for enteric nutrition.

**Q.** How do we code for the oversewing of an ulcer?

**A.** Report code 43840, Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury.

**Q.** How do we code for a laparoscopic liver biopsy?

**A.** Report code 47379, Unlisted laparoscopic procedure, liver.

**Q.** What ICD-9-CM diagnosis code would we use for a mastectomy on a male patient?

**A.** Depending on the site, report either ICD-9-CM diagnosis code 175.0, Malignant neoplasm of nipple and areola of male breast, or code 175.9, Malignant neoplasm of other and unspecified sites of male breast.


**Q.** What code would we use when a skin-sparing mastectomy is performed?

**A.** You would report code 19182, Mastectomy, subcutaneous. If the nipple and areola complex is removed, you would report either code 19180, Mastectomy, simple, complete; or code 19240, Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle modified radical mastectomy. The specific code would depend upon the actual procedure performed.

**Q.** How do we code for a scar revision on a mastectomy site?

**A.** Use the appropriate CPT complex repair code (code 13100 through 13102, Repair complex, trunk...). The CPT introductory remarks regarding repairs specifically mention scar revisions and state that a complex repair requires more than layered closure. Choose the code based on the size of the repaired wound, which should be measured and recorded in centimeters, whether it is curved, angular, or stellate.

**Q.** How do we code for a thrombin injection for a pseudoaneurysm of an extremity?

**A.** Report code 36002, Injection procedures (such as thrombin) for percutaneous treatment of extremity pseudoaneurysm. 

# College news

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## Report of the 2002 Traveling Fellow

by Douglas S. Tyler, MD, FACS, Durham, NC

I had the distinct privilege of attending the Royal Australasian College of Surgeons Meeting this year as the Traveling Fellow of the Australia/New Zealand Chapter of the American College of Surgeons. This fellowship provided an excellent opportunity for me to share my clinical and research experiences with my Australian and New Zealand counterparts. In addition, I had the unique educational opportunity to see how surgical oncology is practiced in another part of the world. The fact that I was able to share this experience with my wife, Donna, and two daughters, Britta (11) and Colby (9), made it all the more enjoyable.

The following report will not only summarize my academic interactions and presentations, but will detail our traveling experiences around the unique Australian continent.

Our trip began May 7, with a long flight to Australia from Los Angeles, CA. By crossing the international dateline we never saw May 8 and landed in Melbourne early in the morning on May 9. This time afforded me the opportunity to develop some preconceived notions about Australia by reading Bill Bryson's travel book, *In a Sunburned Country*. It was there that I learned that although Australia is about the size of the U.S., it has a population of only 20 million people. Most of them are concentrated in eight cities



Left to right: Mrs. Tyler, Dr. Tyler, and Dr. Deane.

(Sydney, Melbourne, Adelaide, Perth, Cairns, Brisbane, Darwin, and Canberra) located around the periphery of the country. The vast portion of the land mass is uninhabited by humans but does harbor a collection of some of the world's most deadly creatures, including the funnel web spider, box jellyfish, paralysis tick, stone fish, and blue-ringed octopus. It is also worth noting that the world's 10 most poisonous snakes are all Australian and that saltwater crocodiles and sharks inhabit Australia's coastline.

I began my Fellowship in Melbourne and had arranged several of our activities with the help of Bruce Mann, MD, a Memorial-Sloan Kettering-trained surgical oncologist who prac-

tices at the Royal Melbourne Hospital. I started my first day in Melbourne at the Peter MacCallum Cancer Institute, hosted by Professor Robert Thomas. We spent the afternoon going over case and research presentations, and I gave a lecture entitled "Pancreatic Cancer in 2002: Where Are We Heading?"

That evening, Dr. Mann and his wife, Susan, who is also a surgeon, treated us to an enjoyable dinner and walking tour of downtown Melbourne. The following morning, May 10, I visited the Royal Melbourne Hospital where I participated in a Tumor Board Conference and met with staff physicians from their oncology unit. Before leaving Melbourne, we traveled south to Phillip Island, where



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we got our first exposure to kangaroos and koalas and watched the famous fairy penguin parade at sunset.

From Melbourne we headed to Adelaide, where the Seventy-Fifth Congress of the Royal Australasian College of Surgeons Meeting was held as a joint congress with the Royal College of Edinburgh. I was welcomed to the conference by Stephen Deane, MD, FACS, President of the Australia/New Zealand Chapter of the American College of Surgeons. He orchestrated much of my conference participation and introduced me to many of his colleagues from Australia and New Zealand.

The five-day conference began May 11. The first meeting I attended was the business meeting of the Australia/New Zealand Chapter of the American College of Surgeons, held May 11, where I presented "What the American Public Expects from a Surgical Oncologist: How Do You Define Excellence?" Additionally, I gave the American College of Surgeons Lecture, "RNA-Pulsed Dendritic Cell Vaccines: Possible New Approaches for Melanoma and Pancreatic Cancer," as part of the surgical oncology sessions on May 13, and a lecture entitled "Neoadjuvant Chemoradiation for Pancreatic Cancer" as part of the hepatobiliary sessions on May 15.

In addition to attending several of the educational sessions, my wife and I also attended the convocation and Syme Oration and the congress banquet. Our host in Adelaide was Brendon Coventry, MD, a surgical oncologist

at the Royal Adelaide Hospital. Dr. Coventry and his family took my family to dinner at a unique nocturnal animal wildlife preserve and showed us around the countryside of Adelaide. Later in the evening we went back to Dr. Coventry's house for tea and enjoyed seeing how our children found so much common ground in such universal subjects as Disney World rides, Harry Potter books, Game Boys™, and Game Cubes™.

Before leaving Adelaide, we took a day trip to the vineyards of Barossa Valley, where we were educated in the magnitude and quality of the Australian wine industry. We also spent time on Kangaroo Island, where we saw colonies of Australian sea lions, New Zealand fur seals, kangaroos, wallabies, and koala bears in their beautiful native habitat.

We spent the middle portion of our trip experiencing some of the natural wonders of Australia. We headed next to the outback and Ayers Rock. Here we saw Uluru (Ayers Rock), which is the world's largest monolith, and the Kata Tjuta (the Olgas) giant rock formations. We watched the beautiful sunrises and sunsets over these unique rock structures, which stick out like mountains in the middle of the vast central outback. We also learned a great deal about the history of the aboriginal people from this part of Australia and developed tremendous respect for their culture.

From Ayers Rock, we headed for Cairns. We had a spectacular time exploring the Great Barrier Reef for several days,

using Palm Cove as a base. We then rented a sport utility vehicle and headed up to Cape Tribulation on the left side of the road where we spent three days exploring the seclusion and beauty of the coastal Daintree Rain Forest. Our kids were horrified to find that our lodging facilities had no telephones, TVs, or minibars. The isolation was disturbed only by a sole Internet cafe, where needless to say we found ourselves each night for dinner, drinks, and, of course, checking e-mails.

The last leg of our trip was spent in Sydney in the company of Dr. Deane and his wife Anne. The Deanes were delightful hosts, showing us the highlights of their amazing hometown of Sydney. On May 27, I spent the morning with Dr. Deane as he showed me around the Liverpool Hospital outside of Sydney. I presented a lecture entitled "New Approaches to the Diagnosis and Treatment of Pancreatic Cancer." Afterward, we went over several case presentations and research talks and toured the hospital facility.

The afternoon was spent at the Royal Prince Alfred Hospital where Andrew Spillane, MD, a consultant surgeon, was my host. My interest in melanoma and regional therapeutics made my time spent at the Sydney Melanoma Unit very rewarding. I regret not being able to spend more time with John Thompson, MD, FACS, chief of the Sydney Melanoma Unit, who I met in Adelaide but did not see in Sydney because of his commitments to administering Australian oral board examinations.

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This report does little to really convey how special my family and I considered our three weeks in Australia. To experience another country's culture, especially through the hospitality shown to us by the Mann, Coventry, and Deane families, is something we will never forget. The interchange of research and clinical ideas was invigorating, especially with regard to melanoma and pancreatic cancer.

Equally stimulating was the comparison between U.S. and Australia clinical practices in surgery in general, and oncology specifically. Through this unique opportunity, I have begun some collaborative projects with Dr. Coventry and hope to pursue some regional therapeutic strategies with the group at the Sydney Melanoma Unit.

I am indebted to the American College of Surgeons for

providing me with this experience and the Australia/New Zealand Chapter of the American College of Surgeons for overseeing the Fellowship. My family and I look forward to returning the hospitality shown to us by our hosts when they visit this country.

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*Dr. Tyler is assistant professor of surgery, Duke University Medical Center, Durham, NC.*

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## 2002 Residents Trauma Papers Competition winners announced

The ACS Committee on Trauma announced the winners of the 2002 Residents Trauma Papers Competition at its annual meeting in San Diego, CA, April 11-13. This year, 12 regional winners received prize money of \$500, with additional first place prize money of \$1,000 and second place prize money of \$500. The Residents Trauma Papers Competition is also funded by the Eastern and Western States Committees on Trauma, Region VII (Iowa, Kansas, Missouri and Nebraska), and the American College of Surgeons.

The competition is open to surgical residents and trauma fellows in the U.S., Canada, and Latin America. Papers are submitted to the individual state or provincial chair. Winning pa-

pers are selected and sent to each region chief so they may conduct a regional competition. Papers describe original research in the area of trauma care and/or prevention categorized in either basic laboratory research or clinical investigation.

Winning papers from 13 regions were presented at the scientific session at the Committee on Trauma Meeting, and the final four winners were announced at the Trauma Banquet. Winning senior authors and their spouses had an expense-paid trip to the meeting. L.D. Britt, MD, FACS, Chair of the Regional Committees on Trauma and ACS Regent, served as moderator.

The 2002 final winners are as follows:

**First Place—Basic Laboratory Research:** Jonas Gopez, MD, Philadelphia, PA, Cox-2 Expression Activity and Inhibition in Traumatic Brain Injury.

**First Place—Clinical Investigation:** Ram Nirula, MD, MPH, Seattle, WA, Crash Test Dummy Analyses Do Not Predict the Likelihood of Injury in Actual Crashes.

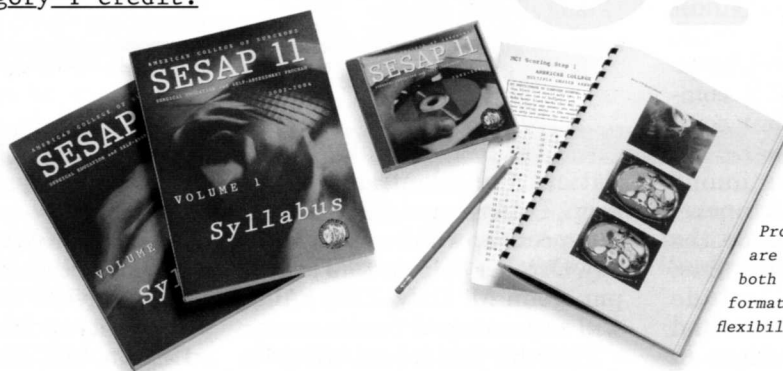
**Second Place—Basic Laboratory Research:** Steven Casha, MD, Burlington, ON, Improved Neurological Outcome and Axonal Survival after Spinal Cord Injury with FAS Gene Deletion.

**Second Place—Clinical Investigation:** Seong K. Lee, MD, San Francisco, CA, Training for Trauma in Simulation: A Prospective Randomized Study.

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From the ACS Archives

## SESAP: A College resource since 1971

by Susan Rishworth, Archivist

Since its inception, the College has sought to assist surgeons in attaining and maintaining the high level of knowledge and understanding necessary to provide optimal patient care. To help achieve this goal, the Committee on Continuing Education, in collaboration with the National Board of Medical Examiners, developed the Surgical Education and Self-Assessment Program (SESAP). Established in 1971, SESAP is designed to serve as a program of self-testing in order to identify gaps in knowledge and then to simplify the task of closing them.

The program is now in its eleventh edition, and the twelfth edition, scheduled for publication in 2004, is being developed, indicating its continued popularity. Ajit Sachdeva, MD, FACS, FRCSC, Director of Education, notes that SESAP will continue to evolve as the College works with the American Board of Surgery (ABS) to implement new directives for maintaining competency. Hence, now may be a good time to recall the history of SESAP through further investigation of the College Archives.

### **SESAP's origins**

The concept of self-evaluation and self-assessment did not originate with the American College of Surgeons. In 1968, the American College of Physicians

(ACP) became the first specialty organization to propose multiple-choice self-testing methods to its members through its Medical Knowledge Self Assessment Program. The ACP was responding to the federal government's 1967 National Advisory Commission on Health Manpower, which recommended that professional societies explore the possibility of periodic relicensing of physicians and other health professionals. It suggested that such relicensing be granted either upon certification of acceptable performance in continuing education programs or upon the basis of challenge examinations in the practitioner's specialty.

The commission was itself responding to public concern about the nation's health care system and the qualifications of its medical professionals. Between its 1967 report and the implementation of SESAP, similar programs were undertaken by the American Psychiatric Association, the American Academy of Pediatrics, the American Society of Anesthesiologists, the American College of Obstetricians and Gynecologists, and the American College of Radiology. Ralph Nader's organization, The Center for Responsive Law, added to patients' fears with its publication of *One Life—One Physician: An Inquiry into the Medical Profession's Performance in*

*Self-Regulation* (Keelty LT, Lam M, Phillips RE, et al) in 1970. These were some of the driving forces that brought the idea of self-testing to the forefront of the American College of Surgeons' agenda.

### **First edition**

The College's Committee on Continuing Education, in 1971 and under the direction of its Chair, James V. Maloney, Jr., MD, FACS, decided to augment the traditional system of continuing medical education. Under this system, a physician gives evidence of having registered for a certain number of postgraduate courses but is not held accountable for the acquisition of new knowledge and skills. The committee appealed to leaders in general surgery to work with the test specialists of the National Board of Medical Examiners to develop multiple-choice questions that would be clinically oriented, carefully constructed, and objective in designated categories and subcategories of surgery. The questions were to deal with information that the committees considered important for the overall design of this educational self-assessment exercise, with particular emphasis on new information. The new program would give surgeons an opportunity, in absolute confidence, to test their own knowledge and then be di-

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rected to sources for filling in gaps.

The Committee on Continuing Education recruited 44 nationally recognized surgeons and appointed them to subcommittees to develop questions in 17 separate categories of surgical knowledge. The subcommittees generated more than 2,000 questions, which, after months of deliberations and modifications, were whittled down to 750. These packages of questions then were mailed to approximately 10,000 surgeons who registered for the privilege of assessing their standing in various fields of surgical knowledge. Before it was finished, 15,000 surgeons had participated in the first edition of SESAP.

### ***Subsequent editions***

The first edition of SESAP so successfully responded to the continuing education needs of surgeons that the second edition followed soon after in 1974, and

it included a syllabus for correcting deficiencies; 20,000 surgeons participated in SESAP II.

The College hoped to make use of the group scores in planning the educational programs for its Clinical Congresses and sectional meetings, and was particularly desirous of making it useful as a preparation for recertification in surgery. The third edition, which was the first that the ACS produced by itself and without the assistance of the National Board of Medical Examiners, appeared in 1979 with the statement that the American Board of Surgery and the American College of Surgeons agreed to correlate SESAP with the board's recertification process.

The clinical and other problems addressed by SESAP, as well as other educational activities of the ACS, then constituted the basis for the questions to be used in the Board's examinations. The third edition included patient management problems,

which were discontinued in later editions in favor of continuing the multiple-choice items and development of software versions.

The first software version appeared in 1988, and the tenth edition included a CD-ROM with more multimedia, voice narration, fully searchable text with individual indexing, a more intuitive interface with additional navigational tools, higher quality images, and the Medline abstract for the journal references. Participants are eligible for 60 hours of Category 1 CME credit if response materials are returned to the College.

Fellows interested in further researching the origins of SESAP, correspondence surrounding its development, unused questions, and other topics related to the College's history may contact Susan Rishworth, Archivist, tel. 312/202-5270, or via e-mail at [srishworth@facs.org](mailto:srishworth@facs.org).

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## **CDC public education brochure on brain injuries available in Spanish**

The Centers for Disease Control and Prevention (CDC) recently developed *Información Acerca de la Lesión Cerebral Leve (Facts About Concussion and Brain Injury)*, a Spanish-language brochure about traumatic brain injuries. The brochure includes information on potential symptoms of brain injury, tips for healing, and resources for help. As such, it is perfect literature for primary

care physicians, emergency physicians, nurses, emergency staff, and neurological specialists to have on hand to help bridge Spanish-English communication gaps.

More than 1.5 million Americans sustain a traumatic brain injury each year, and a distinct lack of Spanish-language public health education materials led the CDC to devote research and funding to the development of

this Spanish-language brochure.

The brochure is free and may be obtained via the Internet. Downloadable copies of both the Spanish and English versions are available at [http://www.cdc.gov/ncipc/lesion\\_cerebral/lesion\\_cerebral.htm](http://www.cdc.gov/ncipc/lesion_cerebral/lesion_cerebral.htm). Hard copies of the brochure may be ordered at <http://webapp.cdc.gov/ixpress/pubsprod/ncipc+book/ncipc.dml>.

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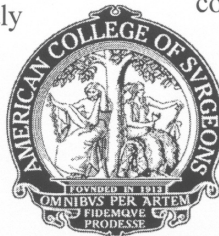
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# Health Policy Scholarship now available for 2003

The American College of Surgeons (ACS) and the Society of Thoracic Surgeons (STS) are offering an annual scholarship to subsidize participation in the course, Understanding the New World of Healthcare: A Healthcare Policy Program for Physicians, Trustees, and Healthcare Leaders, at Harvard University. The course is offered annually in the spring. The award is in the amount of \$8,000, to be used toward the cost of tuition, travel, housing, and subsistence during the period of the course.

General policies covering the granting of the Health Policy Scholarship are:

- The award is open to surgeons who are members in good standing of both the ACS and the STS. Applicants must be at least 30 years old, but under 55 on the date that the completed application is filed.
- The award is to be used to support the recipient during the period of the course. Indirect costs are not paid to the recipient or to the recipient's institution.

Applications for this scholarship must include the following items:

- One original and eight copies of the applicant's current curriculum vitae.
- One original and eight copies of a one-page essay discussing why the applicant wishes to receive the Health Policy Scholarship.

Application for this award may be submitted

even if comparable application to other organizations has been made. If the recipient accepts a similar scholarship from another agency or organization, the Health Policy Scholarship will be withdrawn. It is the responsibility of the recipient to notify the Scholarships Section of the ACS, which administers this award, of competing awards.

The Health Policy Scholarship must be used in the year for which it is designated. It cannot be postponed.

The scholar is required to serve one year as a *pro tem* member of the health policy steering committees of both the ACS and the STS following completion of the course. This obligation includes participation in meetings of the organizations' health policy committees.

A brief report of the scholar's experiences and activities is due at the conclusion of the scholarship period. A simple accounting is required as well.

The closing date for receipt of applications is December 15, 2002. An awardee will be selected by a committee consisting of members of the ACS and the STS. All applicants will be notified of the outcome of the selection process by March 1, 2003.

Further information and applications may be obtained by contacting the ACS Scholarships Administrator at 312/202-5281. Requirements for the ACS/STS Health Policy Scholarship are also posted on the ACS Web site at <http://www.facs.org/dept/fellowship/research.html>.

## Correction

The article "Selecting the best Medicare payment option" (August 2002, p. 16) misstated an important fact about private contracting.

The last paragraph under the subhead "Private contracting" on page 19 should read, "In an emer-

gency situation, a physician who has opted out of the Medicare program may treat a Medicare patient with whom the physician does not have a private contract. In such a situation, the physician may not charge the beneficiary more than what a nonparticipat-

ing physician would be allowed to charge and must submit a claim to Medicare on the beneficiary's behalf."

The Division of Advocacy and Health Policy thanks Benjamin Berry Lecompte III, MD, FACS, for his assistance with this matter.

# Online general sessions from the Clinical Congress

**Offered by the American College of Surgeons  
Division of Education**

In an effort to meet the growing and ever-changing needs of our Fellows and a diverse surgical community, the Division of Education will be offering six online general sessions from the Clinical Congress. These sessions will be offered in the form of a Web cast through the College's Web site approximately four to five weeks after Congress.

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- GS 23: Programa Hispanico**
- GS 34: Should Axillary Dissection  
Be Abandoned?**
- GS 40: Management of Metastatic  
Disease of the Liver**



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## CME Joint Sponsorship Program continues to grow

The American College of Surgeons initiated the CME Joint Sponsorship Program in July 2001. The College is an accredited provider with the Accreditation Council for Continuing Medical Education (ACCME) and assists nonaccredited not-for-profit surgical organizations in providing CME credit for their education activities. This program is designed to be a cost-effective method for smaller nonaccredited societies to comply with ACCME regulations for continuing medical education.

The College has jointly sponsored educational activities with the following societies: American Society of General Surgeons, Western Surgical Society, North Pacific Surgical Association, OSU/Cleveland Clinic, Peripheral Vascular Surgery Society, Pacific Coast Surgical Association, Society of Gynecologic

Oncologists, ASE/APDS Surgical Education Week, Oregon Clinic/Legacy Health System, Columbia University College of Physicians and Surgeons, Society for Surgery of the Alimentary Tract, Society for Maternal Fetal Medicine, Midwestern Vascular Surgical Society, Western Vascular Society, New England Surgical Society, Illinois Association of Orthopaedic Surgeons, and Mission St. Joseph's Health System.

Upcoming jointly sponsored educational activities include:

- Illinois Association of Orthopaedic Surgeons, 2002 Fall Scientific Meeting, Chicago, IL, October 19.
- Mission St. Joseph's Health System, Fourth Annual Trauma and Critical Care Symposium, Asheville, NC, October 19.
- Oregon Clinic/Legacy Health System, Updates: Minimally Invasive Gastrointestinal Surgery,

Honolulu, HI, November 4-8.

- North Pacific Surgical Association, Eighty-Ninth Annual Meeting, Seattle, WA, November 8-9.
- Ohio State University/Cleveland Clinic Foundation, Advances in Minimally Invasive Surgery 2003: Technical Considerations in Laparoscopy, Marco Island, FL, January 31-February 2, 2003.
- The Society of Gynecologic Oncologists, Annual Meeting on Women's Cancer, New Orleans, LA, January 31-February 4, 2003.

Further information may be obtained from the program's administrator, Kathleen Goldsmith, via e-mail at [JSP@facs.org](mailto:JSP@facs.org), or by calling 312/202-5212. Application materials are also available on the ACS Web site ([www.facs.org](http://www.facs.org)) under "Continuing Medical Education."



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## Advances in Trauma seminar set for December

The College's Committee on Trauma, Region VII (Iowa, Kansas, Missouri, and Nebraska) is sponsoring the Twenty-Fifth annual Advances in Trauma seminar at The Westin Crown Center in Kansas City, MO, on Friday and Saturday, December 6-7.

The regional and state chairs have planned a program that will benefit all physicians who are involved in trauma care. Program chairs are: Michael H. Metzler, MD, FACS, Chief, Region VII; Philip R. Caropreso, MD, FACS, Iowa State Chair; R. Stephen Smith, MD, FACS, Kansas State Chair; Marc J. Shapiro, MD, FACS, Missouri State Chair; Joseph C. Stothert, Jr., MD, PhD, FACS, Nebraska State Chair; and Frank L. Mitchell, Jr., MD, FACS, program co-chair.

The objective of this continuing medical education course is to present nationally recognized faculty who will discuss timely trauma and critical care issues aimed at improving care of the acutely injured patient. Current trauma diagnostic and therapeutic techniques will provide the audience with the

most up-to-date information available.

The Friday program will include presentations on: Success in Resuscitation: When Less Is More; Penetrating Trauma Management: Have We Reached a Consensus?; 10 Golden Rules for Multiple Casualty Incidents; Pediatric Prehospital Considerations; Trauma Diagnostic Changes; Genomics of Trauma; Nonoperative Management of Visceral Injury: When to Operate? When to Observe? When to Embolize?; Pediatric Blunt Abdominal Trauma; Trauma Education and Work Hour Restrictions: Can They Get Along?; and Town Meeting: Trauma—Past Accomplishments.

Saturday's program continues with presentations on: ICU Care—Lessons Learned in the Last 25 Years; Blunt Cardiac Trauma; What Price Commitment?; CNS Trauma—BTF Guidelines; Penetrating Cardiac Trauma; Spinal Cord Trauma—BTF Guidelines; A Crash Course in Traffic Safety; and Town Meeting—The Next 25 Years.

Optional "Sunrise Sessions" on Friday and Saturday morn-

ings include: Percutaneous Tracheostomy Course; Ultrasound Orientation; Prehospital Medical Director; Ventilator Associated Pneumonia; Management of the Pediatric Burn Patient; and Avoiding the Diversion Blues.

Faculty members include: Juan A. Asensio, MD, FACS; L.D. Britt, MD, MPH, FACS; Timothy G. Buchman, MD, PhD, FACS; Akella Chendrasekhar, MD, FACS; Elizabeth Carlton, RN, MS, CCRN; Leonard Evans, DPhil; David V. Feliciano, MD, FACS; Robert P. Fogalia, MD, FACS; Thomas M. Foley, MD, FACS; Michael H. Metzler, MD, FACS; Frank L. Mitchell, Jr., MD, FACS; Nelson M. Oyesiku, MB, BS, FACS; Paul E. Pepe, MD, MPH; Thomas M. Scalea, MD, FACS; Marc J. Shapiro, MD, FACS; R. Stephen Smith, MD, FACS; Joseph C. Stothert, Jr., MD, PhD, FACS; Jeffrey Strickler, RN, MA, CEN; Donald D. Trunkey, MD, FACS; and David W. Tuggle, MD, FACS.

Further information may be obtained on the College's Web site at [www.facs.org](http://www.facs.org).

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### IN COMPLIANCE, from page 17

the surgeon can initial will satisfy this requirement.

Patients must be granted a number of rights to be compliant with HIPAA. We will outline those privileges in detail in next month's column. □

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ACS guidance on HIPAA issues is based on information contained in the "Small Practice Implementation Guide" version 1.2 (<http://snip.wedi.org/public/articles/index.cfm?Cat=17>), copyright 2001, The Workgroup on Electronic Data Interchange.

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## CHARITABLE IMMUNITY, from page 10

manual as well. For example, rather than enacting legislation that extends immunity to volunteer clinicians, a few states provide a mechanism for subsidizing the purchase of malpractice insurance. Twelve states have statutory provisions designed to encourage retired physicians to volunteer.

### Federal legislation

Reacting to an environment in which individuals were reluctant to volunteer for fear of liability suits, Congress passed the Volunteer Protection Act (VPA) of 1997. According to the VIH manual, a volunteer clinician acting within his or her scope of duties in a not-for-profit organization is protected from liability for simple negligence. (There are exceptions for misconduct related to crimes of violence, sexual offenses, civil rights violations, and other offenses.) Even when the volunteer is held liable for gross negligence, the VPA limits the award of punitive damages to those cases in which there is clear and convincing evidence of willful or criminal misconduct or conscious, flagrant indifference to the rights or safety of the individual harmed. The VPA also limits awards for noneconomic damages (pain and suffering) to the proportion of harm caused by the volunteer.

The VPA preempts state laws that are inconsistent with the federal statute but does not preempt any state law that provides additional protection.

Like most state statutes, it does not limit the liability of the not-for-profit organization through which the volunteer provides services. Also, like state laws, the VPA does not limit a plaintiff's right to bring suit. Critics say the law's weakness is that plaintiffs will simply claim gross negligence. (A claim that might have tested the VPA—*Momans, et al vs. St. Johns Northwestern Military Academy, Inc., et al*—did not move forward in court.) However, in those states that have weaker or nonexistent protections, the federal law affords at least some measure of protection to the volunteer clinician.

### Conclusion

The VIH manual on charitable immunity laws is available at no charge at <http://www.volunteersinhealthcare.org/Manuals/charit.imm.man.pdf>. Printed copies may be requested by calling 1-877/844-8442 (toll-free). As the manual demonstrates, a variety of liability protections are available to surgeons who want to volunteer their services. Hence, surgeons should not allow fear of lawsuits to stand in the way of giving back to society.

The B/G Committee on Socioeconomic Issues intends to continue to develop and suggest new ways to stimulate interest in volunteerism among Fellows of the College. □

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## FELLOWSHIP PROGRAMS, from page 15

Lure, NC, was one of the first surgeons to participate in the RWJ Fellowship in 1980 (see photo, p. 15). While he enjoyed the concentrated orientation to the way things work in Washington, he found he missed patient care tremendously. For him, the Fellowship experience confirmed that he had made the right decision devoting his energies to patient care. As Dr. Hoopes put it, he "realized there were no greener pastures."

Dr. Hoopes left the experience somewhat disillusioned about the dealmaking and narrow agendas offered by many policymakers and their staff members. Nonetheless, he notes that there is a need for surgeons to help expand those agendas to reflect what is best for patients and practice.

### How to apply

Applications to the White House Fellows program must be postmarked by February 1 each year and are available on the following Web site: <http://www.whitehouse.gov/fellows/>.

For the RWJ Fellowships, applications are due at the Institute of Medicine by November 15 of each year and must include references, a description of a proposed project, and institutional endorsements. Those individuals who are accepted begin Fellowships the following fall. A complete program guide and description of the program are available at [www.nas.edu/rwj](http://www.nas.edu/rwj). For more information, contact Barbara Cebuhar at [bcebuhar@facs.org](mailto:bcebuhar@facs.org). □

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# Chapter news

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*by Rhonda Peebles, Chapter Services Manager, Division of Member Services*

To report your chapter's news, contact Rhonda Peebles (toll-free) at 888/857-7545, or via e-mail at [rpeebles@facs.org](mailto:rpeebles@facs.org).

## **New York Chapter seeks to restore trauma funding**

William H. Marx, DO, FACS, of the New York Chapter, met with representatives of Gov. George Pataki's office in July to discuss the New York Trauma System and Registry. Funding for the trauma system was reduced from \$3 million to \$500,000 in the 2001-2002 state budget. According to Dr. Marx, the trauma system will further decline if funding is not restored quickly. Dr. Marx intends to work on this issue with the Governor's office until a meaningful solution to the problem is found.

## **Dr. Jones attends Brooklyn-Long Island annual meeting**

In early June, the College's President, R. Scott Jones, MD, FACS, attended the annual business meeting of the Brooklyn-Long Island (NY) Chapter (see photo, this page). He updated the chapter members on current College activities.

## **Florida Chapter honors Dr. Gage**

The Florida Chapter presented The Raymond H. Alexander, MD, Award to John O. Gage, MD, FACS, last June. The chapter presents this award to recognize outstanding dedication and service to the medical profession in the field of surgery as exemplified by the devoted and unselfish Dr. Alexander.

Dr. Gage has been a member of the Florida Committee on Trauma since 1981 and is a former chapter officer and ACS Governor. In addition to his leadership activities at the chapter level, Dr. Gage currently serves as Secretary of the College and chairs the ACS General Surgery Coding and Reimbursement Committee.



Brooklyn-Long Island Chapter (left to right): Robert F. D'Esposito, MD, FACS, Secretary; Richard W. Golub, MD, FACS, President-Elect; Anthony Tortolani, MD, FACS, President; and Dr. Jones.

## **Colorado Chapter hosts competition for residents**

During its June 6-8 annual meeting in Breckenridge, the Colorado Chapter hosted a paper competition for residents. The winners included:

First place: C.C. Cothren, MD,\* Characteristic Radiographic Findings of Post-Injury Splenic Autotransplantation: Avoiding a Diagnostic Dilemma.

Second place: K. Barsmess, MD,\* Hemorrhagic Shock Activates the Endotoxin Receptor.

Third Place: C. Raeburn, MD,\* Clinical Accessible Mediators of Sepsis-Induced Cardiac Dysfunction.

## **Chapter performance benchmarks under review**

The Governors Committee on Chapter Activities is reviewing its "best practices" for chapters, which

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\*Denotes participant in the Candidate Group.



were devised a few years ago. The current best practices include:

1. Chapter meetings are held for the chapter only, or, at most, with state-level surgical societies.
2. Important aspects of successful chapter meetings include: (1) the involvement of surgical residents in the program; (2) presentations on cancer and trauma; and (3) surgical subspecialty program presentations.
3. Special invited scientific speakers, residents paper competitions, and continuing medical education accreditation are important aspects that “draw” Candidates and Fellows to chapter meetings.
4. Strong chapters place greater importance on initiatives for women surgeons and minorities, especially in meeting and program design. This emphasis on diversity results in better participation in chapter activities among Fellows, Associate Fellows, and Candidate Group participants.
5. Accredited continuing medical education is very important.
6. Chapter executive councils meet more than once per year.
7. The chapter should have active committees, programs, or initiatives in cancer, trauma, young surgeons, membership, continuing education, and socioeconomic and legislative issues.
8. Computers and newsletters are used frequently or extensively as a means to facilitate communications.

## New Jersey Chapter conducts liability premium survey

In response to a request from the Chapter’s Hospital Liaison Representatives, the New Jersey Chapter surveyed members regarding premiums for professional liability insurance. In all, 332 questionnaires were returned, and the responses indicated that: (1) average insurance premiums for general surgeons were \$31,000 per year; (2) average premiums for vascular surgeons were \$40,300 per year; and (3) average premiums for vascular surgeons were \$36,600 per year.

For more information about the New Jersey Chapter liability premium survey, contact Art Ellenberger, Executive Director, at 973/239-2826.

## Chapter anniversaries

Month	Chapter	Years
October	Alabama	51
	Belgium	3
	San Diego (California)	29
	Manitoba (Canada)	46
	Colombia	37
	Jacksonville (Florida)	45
	France	15
	Delaware	45
	Hong Kong	7
	India	9
	Kansas	51
	Jamaica	10
	Japan	15
	Federal District (Mexico)	42
	North Carolina	46
	Ohio	46
	Panama	5
	Metropolitan Philadelphia	16
	Saudi Arabia	11
	South Carolina	52
	Switzerland	3
	<b>Tennessee</b>	<b>50</b>
	North Texas	32
	South Texas	32
	Thailand	5
	Utah	51
	Virginia	37
	Venezuela	36
	Vermont	52

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# Next month in *JACS*

The November issue of the *Journal of the American College of Surgeons* will feature:

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Charles G. Drake History of Surgery Lecture:

The Saga of Liver Replacement

Collective Review:

Stem Cells and Myocardial Repair

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Original Scientific Articles:

- The Nationwide Frequency of Major Adverse Outcomes in Anti-reflux Surgery and the Role of the Surgeon Experience, 1992-1997
- When to Remove a Chest Tube? A Randomized Study with Subsequent Prospective Consecutive Validation

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Palliative Care:

Dilemmas within the Surgical Intensive Care Unit

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What's New in Surgery:

Urology

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